

## **Hospital Palliative Care Advisory Group**

**December 17, 2013**

### **Meeting Summary**

**Attendance:** Regina Bodnar; Yvonne D’Arcy; Joan Daugherty; Peter Graze; Cathy Hamel; Evonne Kaniecki; Debbie Lemke; Cathy Livingston; Rene Mayo; Angela Poppe Ries; W. Anthony Riley; Amy Shives; Tom Smith; Meredith Truss; Allen Twigg; Jaya Vijayan; Katherine Walker; Steven Wilks; Julie Wright; Katie Wunderlich; Ivan Zama.

**Staff:** Linda Cole; Erin Dorrien; Rebecca Goldman; Bruce Kozlowski; Paul Parker; Srinivas Sridhara

#### Welcome and Introductions:

Paul Parker welcomed the hospital representatives and other members to the first meeting of the Hospital Palliative Care Advisory Group. Eleven hospitals were represented including: Carroll Hospital Center; Doctor’s Community Hospital; Greater Baltimore Medical Center; Holy Cross Hospital; Johns Hopkins Hospital; MedStar Union Memorial Hospital; Meritus Medical Center; Peninsula Regional Medical Center; Suburban Hospital; Union Hospital; and Upper Chesapeake Medical Center.

#### Background Discussion:

Linda Cole briefly reviewed the legislation, including the definition of palliative care. In the legislation, the Commission is charged with studying at least five palliative care pilot programs in hospitals with 50 or more beds. The programs are required to report data on costs and savings to the hospitals and providers, access to care and patient choice, and report on best practices that can be used in the development of standards.

Ms. Cole noted that the palliative care legislation was discussed by the Commission at the November, 2013 meeting and two important messages were conveyed. First, Commissioner Fran Phillips emphasized that collection of data on use of palliative care services by race and ethnicity is very important and the study should attempt to address the problem of disparate use of palliative care services by racial minorities. Additionally, Commissioner Michael Barr and others are interested in understanding palliative care delivery beyond the hospitals’ walls and asked staff to address, to the extent possible, how these services can be coordinated with community-based services and outpatient care programs.

Finally, Ms. Cole reviewed staff’s work to date. Staff consulted with the Maryland Hospital Association and the Office of Health Care Quality on what was known about the existence and characteristics of hospital palliative care programs, and staff conducted a survey of the identified programs to assist in developing a process for choosing pilot program participants.

Rebecca Goldman reported on the results of the survey of Maryland programs. Many of the representatives for hospitals present at this meeting have already discussed their programs in detail

with Commission staff during this interview process. Between August and September, MHCC staff obtained general information via telephone interviews from almost 20 hospitals to better understand the current state of Maryland hospital palliative care programs and to help determine the metrics and thresholds to be used in the Request for Applications for pilot programs for this project. Findings included:

- One program in Maryland is Joint Commission certified (Union Memorial). Four palliative care programs reported that they were considering applying within the next two years.
- All but two hospitals treat inpatients on a consultation basis, providing care to patients in their primary diagnosis setting. Two programs treat palliative care patients in beds dedicated for that purpose (Johns Hopkins and Meritus— both invited pilot programs).
- No program is exclusive of the type of patients or diagnoses they treat. All programs take consultation referrals from any unit to determine eligibility.
- Most programs are staffed for at least a traditional Monday to Friday, 40-hour workweek schedule. Programs that had a “work week” schedule generally report that they feel this availability was sufficient to treat patients for palliative care. Three programs reported being staffed with a member of the palliative care team for seven days a week during the day. The remainder of the programs had staff on-call after normal business hours.
- All programs interviewed are strongly integrated with hospice. In several programs, a hospice provider is actively engaged in both programs. For example, a hospice staff member participated in interviews for Peninsula Regional, Anne Arundel, and Greater Baltimore Medical Center. Staff members are trained to identify the needs of both palliative care and hospice eligible patients at many hospitals.
- All but two programs listed a physician as part of their palliative care team.
- Staff training often includes modules from national palliative care leadership groups including: End-of-Life Nursing Education Consortium (ELNEC), Medical Orders for Life-Sustaining Treatment (MOLST), Virginia Commonwealth University, and University of Wisconsin. For almost all programs, staff members attend regular rounds, and weekly, monthly, and annual meetings or conferences related to palliative care or to share the benefits of palliative care with non-palliative care providers.
- All programs reported that they assess family member or caregiver needs in some way. While these interviews suggest that not all programs have a dedicated social worker as part of the palliative care team, most have access to social workers if needed.
- Approximately half of all interviewees reported that their program is fully integrated with an electronic medical record system, while the other approximately half cited limitations. This issue will have to be addressed in more detail for this project.

- Barriers to Joint Commission certification include 24/7 care requirement, requirement to have full-time administrative position, data collection requirements, difficulty in recruiting qualified personnel, and certification costs.

This information, along with additional survey information from the Maryland Cancer Collaborative and the Center to Advance Palliative Care (CAPC) will be used to gauge baselines and, ultimately, develop recommendations for some of the group's charges.

Paul Parker then reviewed the charge to the group:

The charge of the Hospital Palliative Care Advisory Group is to assist Commission staff in: 1) developing the questions to be addressed in the study and a standard set of core measures to be used in answering these questions; 2) analyzing and interpreting the study data collected in order to make recommendations regarding findings and conclusions on the study questions; and 3) assisting with the development of recommendations on best practices, from the literature, the pilot hospitals' experience, and/or the findings and conclusion of the study. The Commission will have final approval of study questions, data measures, the hospitals that will participate, and all reports and recommendations that are developed.

#### Review of Draft Study Questions and Draft Core Data Set:

Paul Parker reviewed the draft Study Questions and referred to the draft Core Data Measures as an attempt to list the types of data that would be needed, which led to a general discussion by the Group. Key points emerging from this discussion are as follows:

- Each hospital is its own incubator of palliative care, but there is obvious value in having a standardized set of data collected in order to address the issues outlined in the law.
- Measuring "cost savings" associated with palliative care will be difficult. The relevant research literature typically attempts to measure "cost avoidance".
- Most programs fall within the "consultative" model; they collect some data on patients referred, but not on others who might be eligible or might have refused such care.
- A significant barrier to the use of palliative care services is physician referral. Patients may be referred "late" (with respect to the point in time where they could have benefited from palliative care) because their physicians did not think they were ready for palliative care. This can be related to confusion about the differences between hospice and palliative care.
- One variable that should be identified is the specialty of the referring physician.
- Suburban Hospital reported that they used a social worker in the ICU to assess patients and, under their screening model, 85% of ICU patients were evaluated as qualified for palliative care.
- It is difficult, and very resource intensive, to identify and study an appropriate "control" patient group. However, a "comparison" patient group" can be more readily identified.
- Some variables reported in the literature cannot be feasibly collected by all hospital palliative care programs.

- Research needs to distinguish between “early” and “late” consults for palliative care because the costs and benefits of palliative care will vary substantially between these two patient categories. In some ways, initial consultation that occurs when a patient is admitted to the hospital is often already later than optimal.
- There was a discussion of the use of “retrospective” and “prospective” data in the study and whether the nature of the study would be retrospective or prospective.
  - It was noted that the study could use both approaches and that the law implied prospective research.
  - The difficulty or impossibility of collecting some of the draft core measures was noted.
  - The view was expressed that the data set reported annually by the programs to the Center to Advance Palliative Care (CAPC) may meet the needs of the study and would be a standardized data set. The difficulty of obtaining information on costs, rather than charges, was noted.
  - Additionally, the fact that hospitals have different rate setting models (charge per case for some, total patient revenue for others) presented challenges in standardization of charge information across all hospitals.
- Operational differences among programs were noted (e.g., some have private attendings; some have residents; some are nurse directed). Most do not offer 24-hour coverage or service/consultation capability. Only Union Memorial Hospital is Joint Commission certified.
- Regarding the draft core measures, there was a consensus that many listed on the first page are available; however, information on household income was not collected. Income data for the program service area, defined by patient origin, could provide a proxy approach to evaluating the socio-economic status of the patient population.
- It was noted that many programs conduct their own internal studies and the pilot program study could entail collection by all hospitals of a core set of data measures supplemented by a sampling approach, in which a smaller number of programs would agree to collect additional data measures of interest for a brief time (e.g., one quarter or six months).
- There is not a common list of “triggers” or “screens” used by all hospital palliative care programs. Programs see patients that are referred to them.
- Staff suggested that the Health Service Cost Review Commission (HSCRC) hospital discharge data base could be used in the study, providing an existing way to collect a uniform set of data. However, several hospitals stated that the V-code (V66.7) field for identifying a patient as “palliative care” does not provide an accurate representation of the palliative care patient population.
- In hospitals with established palliative care programs, there is diffusion of knowledge on palliative care, so the principles are used, even when the patient is not seen by palliative care staff.
- It was suggested that since all the hospitals represented at the meeting report information to CAPC on an annual basis, this survey data should be utilized as a standard source of data for the study. It was noted that CAPC just changed its data items for the current year. This data source could be used both retrospectively and prospectively; It was noted that this is not a patient-

level data base, so addressing some of the issues included in the law would not be possible with this data set.

- There are two types of data that can be collected: descriptive data on the hospital palliative care programs and descriptive data on the palliative care patient population and its experience.

Next Steps:

It was suggested that Mondays and Fridays are not good days for meetings. Commission staff will send out a Survey Monkey to set up the next meeting.

Staff will follow up with obtaining data from the CAPC registry. We will talk to CAPC staff about obtaining data releases.

Staff will survey programs about the level of data collection currently done or possible for the draft core measures.